Rights and Responsibilities

A guide to the Mental Health Act

Ministry of Health
Ontario

This booklet has been prepared as a guide and reference to the Mental Health Act.

For detailed information about the changes and additions to the Act, please refer to the legislation.

Additional copies of this booklet, free of charge, and copies of the consolidation of the Act and amendments, at nominal cost, are available from the Ontario Government Bookstore, 880 Bay Street, Toronto, Ontario M7A 1N8; (416) 965-2054.

INDEX

About the Act 3

Civil commitment

Clarification of criteria 5
Role of physician 6
What the physician will do 7
Release of person 7
Justice of the peace 8
Constable or peace officer 9
Actions without an order 9
At the facility 10
Judge's order 10
Treatment of involuntary patients 10
Role of review boards 11
Certificates of renewal 12
Communicating with patient 13
Leave of absence 13
Unauthorized absence 13
Mentally ill persons entering Ontario 14

Confidentiality of psychiatric records

Non-disclosure of clinical record ... 15
Exceptions 15
Consent form for disclosure 16
Disclosure in court 17

Role of public trustee

Patients' competence to manage their estates 18
Certificate of incompetence 19
Appeal to regional review board 19
Public trustee as committee 19
Discharge of patient 20
Accounting 21
Offences 21
Appendix I — Definitions 22
Appendix II — Forms 24


LIBRARY
JUL 20 1984

About the Act

Mental illness is a major health problem in Canada. Statistics indicate that a high proportion of people will, at some point in their lives, require hospitalization because of mental disorder.

So it is essential to have a Mental Health Act that gives clear guidance for everyone concerned with the fair and equal treatment of those who need mental health care.

Fortunately, in our society today, much of the "fear of the unknown" has disappeared from our treatment of the mentally ill. We have come a long way from the days when the mentally ill were simply "put away," out of sight and out of mind.

Many changes in mental health services

In the past 25 years, vast changes in the delivery of mental health services have taken place. For example:

- modern chemotherapy was introduced, including the major tranquillizers and anti-depressant drugs.
- the philosophy of treatment in the community, with hospitalization as a last resort, has reduced the numbers of patients in our psychiatric institutions by two-thirds.
- services were developed in the community where the patient lives; for example, psychiatric services are now offered in 60 general hospitals across Ontario, out-patient services are offered by provincial psychiatric hospitals, and a wide range of community support services have been developed.
- new treatment programs and support services offered include rehabilitation services, day care, counselling services, residential accommodation, approved homes, sheltered workshops and volunteer programs.

In recent years, the number of people treated for psychiatric problems on a voluntary basis has increased enormously. Today, 75 per cent of those in Ontario's psychiatric hospitals are voluntary patients. Much of this increase can be attributed to the growing recognition of mental illness for what it is; an illness like any other illness.

Advances in treatment that make possible easier and sometimes dramatic improvement, together with a better understanding of mental illness, are clear indications of progress toward better control and alleviation of mental illness.

But while changes in attitude and treatment methods were taking place over the past decade, the surrounding legislation was standing still. There was also confusion about some of the terms in the legislation.

Designed to clarify

For instance, the amended Act of 1978 is designed to clarify the criteria for commitment. Until 1967, Ontario permitted a person to be confined indefinitely on the certificate of two physicians who stated that the person was "mentally ill." At that time, mental illness was defined as "suffering from such a disorder of the mind that he requires care, supervision and control for *his own protection or welfare, or for the protection of others.*"

In 1967, this was changed to *"in the interests of his own safety, or the safety of others."* Any such person, who required hospitalization and was considered not suitable for admission as an *"informal (voluntary) patient,"* could be admitted to a psychiatric facility as an *"involuntary patient"* and detained for up to one month on the certificate of one physician.

The term "safety" proved open to many interpretations. Some legal advisors cautioned physicians against taking the meaning too broadly. So many doctors certified only people who demonstrated suicidal or homicidal tendencies. Other physicians considered a threat to a patient's reputation, financial status or family stability appropriate grounds for commitment under the safety concept.

Justices of the peace, with the power to order examinations under the law, were also reluctant to do so for fear of misinterpreting "safety."

An issue for the legislature

Such an issue had to be decided by the legislators, whose role it is to translate community values and policies into definitions with which people can work.

What was changed

Three main areas were dealt with in the 1978 amendments. These are highlighted in this booklet in three sections:

- civil commitment;
- confidentiality of psychiatric records; and
- the role of the public trustee.

Additional amendments regarding the ability of a person to designate someone to manage his or her estate in lieu of the Public Trustee were enacted in 1983.

When and why a physician may make an Application for Psychiatric Assessment

The Act states that:

"Where a physician examines a person and has reasonable cause to believe that the person,

a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

c) has shown or is showing a lack of competence to care for himself,"

and if in addition, the physician "is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

d) serious bodily harm to the person;

e) serious bodily harm to another person; or

f) imminent and serious physical impairment of the person;

the physician may make application, in the prescribed form, (Form 1) for a psychiatric assessment of the person."

Clarification of the criteria

Under the old provisions of the Act, confusion over such things as the meaning of the word "safety" underlined the need to clarify the criteria for commitment for everyone concerned with mental health care. This is a vital area, which must not be ambiguous or unclear to either patients or professionals.

Still an "opinion" — not a guarantee

The amendment that sets out the 1978 criteria for assessment and commitment specifically describes the nature of the evidence required and the grounds for action by a physician.

The amendment gives a physician latitude in forming an opinion based on his or her belief, either through his or her observations, or on the basis of facts revealed by others.

It is important to emphasize that a physician need not be *certain* that *"serious bodily harm"* will result before he or she acts.

This is very much a judgment call, as indicated by the word *"opinion"* in the Act.

In law, an error in judgment is not actionable. It must be proved that the defendant-physician was negligent, by establishing that reasonable physicians, in the same circumstances, would have come to a different decision.

The physician is asked to determine whether a person is "apparently" suffering from a mental illness "likely" to result in serious physical harm if the person is not hospitalized.

The physician need not be *certain* that a mental disorder exists. This is emphasized by the word *"apparently."* And serious bodily harm need only be a *"likely"* result of the illness.

Voluntary Admission

Any person believed to be in need of the observation, care and treatment provided in a psychiatric facility may be admitted as an informal (voluntary) patient on the recommendation of a physician.

Commitment

The Application for Psychiatric Asessment (Form 1) must state that the physician who signs it personally examined the person, and made careful inquiry into all the facts necessary to form his or her opinion of the nature and quality of the mental disorder.

The physician must also set out the facts on which that opinion was formed, distinguish between the facts observed and the facts communicated by others, and note the date of examination.

Only seven days

The physician's Application for Assessment (Form 1) must be signed within seven days after the initial examination. This emphasizes the need to act quickly where a serious threat exists. For seven days after the physician has signed it (a reduction from 14 days), the application is sufficient authority for any person to take the subject of the application *in custody* to a psychiatric facility, to detain the person in the facility, and to restrain, observe and examine the person there *for not more than five days.*

The provision uses the words "take in custody" to clarify the authority of the application to provide for the use of *reasonable force* to take a person to a psychiatric facility if that person refuses to go voluntarily.

When the person arrives at the facility on the basis of an Application for Assessment, the facility may admit the person voluntarily, if the person agrees, and can then disregard the application.

Under the earlier provisions of the Mental Health Act, a person could be held in a psychiatric facility, for up to one month, on the written declaration of one physician that the person was a safety risk to himself or others.

Under the 1978 provisions of the Act, a person can be held for a maximum of five days. At any time during this period, of course, the patient may become an informal (voluntary) patient or may be discharged.

The opinion of another physician must be obtained during the five days if the patient is to be detained as an involuntary patient. The second physician completes a Certificate of Involuntary Admission (Form 3), which is then sufficient authority to detain the person further, *for up to two weeks.*

What the attending physician will do during the five-day period

After observing and examining a person named in an Application for Psychiatric Assessment, the attending physician will release the person from the psychiatric facility if the physician feels the person does not need treatment.

Or the physician will admit the person as an informal (voluntary) patient if the physician feels the person is suitable for such admission and in need of treatment.

If, however, the physician is of the opinion that the person is suffering from mental disorder "of a nature or quality that likely will result in serious bodily harm to the person, or to another person, or imminent and serious physical impairment of the person," unless the person remains in the custody of the psychiatric facility, and the physician is of the opinion that the person is not suitable for admission as an informal patient, the physician will admit the person as an *involuntary patient.*

The physician does so by completing and filing with the officer in charge a Certificate of Involuntary Admission (Form 3).

Importance of a "second opinion"

The physician who completes the Certificate of Involuntary Admission must not be the same physician who completed the Application for Psychiatric Assessment.

This requirement for a "second opinion" ensures that no person will be admitted as an "involuntary patient" unless appropriate criteria are identified by at least one physician in a psychiatric facility.

Release of person by officer in charge

The officer in charge of the psychiatric facility has the responsibility to release the individual after five days — unless the attending physician has already done so, or has admitted the person as an informal patient, or completed the Certificate of Involuntary Admission that is authority to detain the person for up to a further two weeks; in total, a maximum of 19 days from initial confinement.

When and why an order for psychiatric assessment may be made

Changes from the old provisions were made in 1978 to define and clarify the justice's role.

The 1978 amendments have deleted the provision requiring that this route be used *only as a measure of last resort.* Justices of the peace have been reluctant in the past to issue orders for fear of liability. Understandably, they have been concerned as to their duty to make "due inquiry into all of the facts."

Neighbors, relatives and others who might not be able to proceed via the route of a physician have this option. A justice of the peace is able to act on information before him where he has reasonable cause to believe the person is apparently suffering from a mental disorder. The justice of the peace issues an order on the basis of sworn information.

The change in the provision is consistent with the new 1978 rules for the physician. Where information, *upon oath*, is brought before a justice of the peace that a person within the limits of his jurisdiction,

"a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

c) has shown or is showing a lack of competence to care for himself,"

and if, in addition — based upon the information before him — the justice of the peace has reasonable cause to believe the person is apparently suffering from mental disorder of a nature or quality likely to result in,

"d) serious bodily harm to the person

e) serious bodily harm to another person; or

f) imminent and serious physical impairment of the person,"

the justice of the peace may issue his Order (Form 2), for the assessment of the person by a physician.

A justice of the peace is not required to make a medical diagnosis. Based on the evidence supplied by way of sworn information, the justice must believe, on reasonable and probable grounds, that the individual described is *apparently* suffering from mental disorder of a certain degree. Once the justice has formed this belief, he may order the individual to be taken to an appropriate place (a health facility, where possible) for initial assessment by a physician.

It is important to recognize that the result of this order will be to gain a medical opinion; it is not in itself sufficient authority to detain a person any longer than necessary for initial assessment.

Seven-day authority for constable or peace officer

The Order for Assessment (Form 2) is sufficient authority for seven days for any constable or peace officer, to whom it is addressed, to take the person named or described in the order "in custody forthwith" to "an appropriate place where he may be detained for assessment by a physician," which must be conducted promptly.

Only the Form 1 issued following this assessment by the physician is sufficient to detain the person for up to five days.

Where practicable, the place of assessment will be a psychiatric or other health facility.

Actions a constable or peace officer can take without an order

Under the Act, where a constable or other peace officer observes a person who acts in a manner that in a normal person would be disorderly, *and* has reasonable cause to believe that the person,

"a) has threatened or attempted or in threatening or attempting to cause bodily harm to himself;

b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

c) has shown or is showing a lack of competence to care for himself,

and if, in addition the constable or other peace officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

d) serious bodily harm to the person;

e) serious bodily harm to another person; or

f) imminent and serious physical impairment of the person,"

and it would be dangerous to wait until an assessment order could be obtained from a justice of the peace, the constable or other peace officer may take the person in custody to an appropriate place for initial assessment by a physician, which must be conducted promptly. The provision permits the constable or peace officer to take the person for this initial assessment rather than laying a charge.

Again, only the Form 1 issued following this initial assessment by the physician is sufficient authority to detain the person for up to five days for a psychiatric assessment and, where practicable, the place of initial assessment must be a psychiatric or other health facility.

The grounds for action by a peace officer coincide with the criteria for physicians and justices of the peace. In addition, the peace officer must *observe* behavior that in a normal person would be disorderly.

Peace officers have not abused their specific powers under the 1967 Act and have demonstrated a high level of competence to identify people in need of immediate psychiatric care.

Constable's duty at facility

A provision stipulates that a constable, or other peace officer, or anyone else who takes a person in custody to a psychiatric facility *shall remain there* and retain custody until the facility accepts custody of the person. This does not necessarily require the peace officer or other person to remain until the person is admitted. Once custody is accepted by the facility, the peace officer or other person may depart.

This provision will prove particularly useful when a peace officer or other person delivers an individual and there may be some delay before appropriate staff can accept custody.

Moreover, since 1978 there has been legislative recognition of such a duty, and peace officers can justify to their dispatchers and superiors any delay at a facility.

Because of the potential danger involved in abandoning an individual in certain instances, this obligation reflects the desirability of a peace officer's continued presence, in some circumstances. The peace officer's duty is to *remain until effective control has been transferred*.

If a judge has reason to believe a person who appears before him charged with or convicted of an offence is suffering from mental disorder, the judge may issue an Order for Attendance for Examination (Form 6), which will require the person to attend a psychiatric facility for examination.

There has been no change to the Act or the procedure in this regard, or to the section permitting a judge to remand any person in custody, who appears before him charged with an offence, through an Order for Admission (Form 8) for admission as a patient *for a period of not more than two months.*

Persons detained under the Criminal Code

The Act also sets out that any person who, under the Criminal Code is remanded to custody for observation or detained under authority of a Warrant of the Lieutenant Governor, may be admitted to, detained in, and discharged from a psychiatric facility in accordance with the law.

Treatment of involuntary patients

Ontario has provided for the giving of treatment without consent to involuntary patients under carefully controlled circumstances.

Where consent, by or on behalf of an involuntary patient, cannot be obtained, psychiatric treatment can be ordered by a Regional Review Board under certain circumstances. To obtain such an order, the officer in charge of the facility and the attending physician must apply to a board (Form 9).

This application must be accompanied by three statements (Form 20) — of the attending physician; a psychiatrist who *is* a member of the medical staff of the psychiatric facility; *and* a psychiatrist who *is not* a member of the medical staff of the facility. The statements must indicate that the proposed psychiatric treatment is necessary and in the patient's best interests.

This order is sufficient authority to provide the psychiatric treatment specified in the application. An order cannot be obtained to provide other medical treatment (non-psychiatric) against a competent involuntary patient's will.

Psychosurgery, for the purpose of behavior control, cannot be performed on involuntary patients. Psychosurgery is defined in the Act as:

"Any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of histologically normal brain tissue, or which inserts indwelling electrodes for pulsed electrical stimulation for the purpose of altering behavior or treating psychiatric illness." It does not include "neurological procedures used to diagnose or treat organic brain conditions or to diagnose or treat intractable physical pain or epilepsy, where these conditions are clearly demonstrable," nor does it include electro-convulsive therapy.

Role of the regional review boards

Immediately on becoming an involuntary patient, or immediately upon a renewal certificate coming into effect, a patient, or any person on a patient's behalf, may apply to a regional review board (Form 16) for a hearing to determine whether or not the legal requirements for commitment have been met.

New protections

Certain provisions were passed in 1978 but were not brought into force until 1984. One of these requires that as soon as involuntary certificates (including renewal certificates) are completed, both Legal Aid and the patients who are the subjects of these certificates, must be informed of this fact and advised that they have a right to a hearing by the regional review boards. Another series of provisions change the procedures of these boards at hearings and require that patients be afforded greater rights, including the right to see any and all material that is before the boards. For the first time, there will be a right to appeal the board's decision to the courts. This right of appeal applies to all areas under the jurisdiction of the boards, including review of the involuntary committal and renewal certificates, decisions regarding treatment orders, and decisions about findings of incompetence to manage estates.

Automatic review at regular intervals

Another new provision as of 1978 provides for automatic review by the regional review boards, for involuntary patients continuously detained for up to six months, two weeks and five days; and yearly thereafter. This represents the maximum time that could elapse between the admission for psychiatric assessment and the completion of the fourth Certificate of Renewal of an involuntary patient.

This automatic review precludes the possibility that patients, unaware of their rights, or reluctant to apply, could spend a considerable period of time involuntarily detained in a psychiatric facility without *independent* consideration of their status.

It is important to recognize that under Ontario's system of review, the review mechanism may be initiated by patients themselves, by someone on their behalf, by the Minister of Health, the Deputy Minister, or the officer in charge of the psychiatric facility.

Certificates of renewal for periods of detention

The criteria for completing Certificates of Renewal (Form 4) were brought into line with those for involuntary certification in 1978.

Under the old provisions, the period of detention of an "involuntary patient" could be extended by Certificates of Renewal for additional periods of two, three, six and 12 months, and yearly thereafter.

Under the new provisions, an involuntary patient may be "detained, restrained, observed and examined" in a psychiatric facility:

a) *for not more than two weeks* under a Certificate of Involuntary Admission, and

b) *for not more than one additional month* under a first Certificate of Renewal; *two additional months* under a second; and *three additional months* under a third or subsequent certificate.

These 1978 changes clarify the authority and responsibility of the facility, while the new schedule reflects a marked reduction in the length of subsequent periods of involuntary hospitalization, with correspondingly more frequent access to a regional review board.

Change from involuntary to informal status

At any time, the attending physician may change the status of an involuntary patient to that of an informal patient (Form 5)

Communication to and from patients

There has been no change in this part of the Act, which states that "no communication written by a patient or sent to a patient shall be opened, examined or withheld, and its delivery shall not in any way be obstructed or delayed."

This applies unless the officer in charge of the facility, or a person acting under the officer's authority, has reasonable and probable cause to believe that the contents of a communication written by a patient would prejudice the patient's best interests, or be unreasonably offensive to the person receiving it, or that the contents of a communication sent to a patient would interfere with the patient's treatment or cause the patient unnecessary distress.

In such circumstances, the officer in charge of the facility, or a person acting under the officer's authority, may open and examine the contents of the communication. If any of the above conditions exist, the officer may "withhold such communcation from delivery."

Under no circumstances, however, may a communication be opened that is written by a patient to — or appearing to be sent to a patient by — a barrister and solicitor, a member of a regional review board or advisory review board under this Act, or a member of the legislature.

Leave of absence — three-month limit

Unless a patient is subject to detention other than under the Act, the officer in charge may — upon advice of the attending physician — place the patient on "leave of absence" from the psychiatric facility, upon such terms and conditions as the officer in charge may prescribe, *for a designated period of not more than three months.*

Unauthorized absence of a patient

Where a person who is subject to detention is absent without leave, a constable or other peace officer — or anyone appointed by the officer in charge — may return the person to the psychiatric facility or take the person to the facility nearest the place of apprehension.

After the person's absence has become known to the officer in charge, a constable may act without an order signed by the officer in charge *for the first 24 hours* and *for up to one month* under the authority of an Order for Return (Form 9) signed by the officer in charge of the facility.

Occasionally, patients leave a facility in one part of Ontario and travel to another part of the province some distance away. In the past, many general hospitals have been reluctant to hold such patients, particularly patients who have left a provincial facility, pending their return to where they were originally detained. All Schedule 1 psychiatric facilities have a responsibility to cooperate in this endeavor.

In certain cases, it may be appropriate to provide continuing care and treatment in the psychiatric facility *nearest the place where the person was apprehended,* rather than returning the person to the original facility.

Transfers of patients

The Act permits transfers of a patient from one facility to another, or to a public hospital for medical treatment, or to an institution outside Ontario, if the patient's hospitalization is the responsibility of another jurisdiction, or in the patient's best interests.

Mentally ill persons coming into Ontario

Where the Minister of Health has reason to believe there may come or be brought into Ontario "a person suffering from mental disorder of a nature or quality that likely will result in serious bodily harm to the person, or to another person" unless that individual is placed in the custody of a psychiatric facility, the Minister may authorize anyone to take the person in custody to a facility.

The order (Form 13) is also authority to admit, detain, restrain, observe and examine the person there for five days.

This change restricts the authority of the Minister to issue an order to take someone to a psychiatric facility — and hold that person there for up to five days — to situations where the individual *represents a physical threat to himself or to someone else.*

This provision is most often used where Ontario residents, detained in facilities outside the province, are returned to Ontario.

Confidentiality of psychiatric records

Non-disclosure of clinical record

A provision states that, with certain exceptions, *no person shall disclose, transmit or examine the clinical record of a psychiatric patient.* The Mental Health Act provisions respecting confidentiality do not apply to professionals in private practice. Other legal sanctions (e.g. the Health Disciplines Act) and in general, professional ethics, require all physicians to keep confidential anything disclosed to them by their patients. Improper disclosure constitutes professional misconduct.

With the advent of such concepts as treatment teams and the increase in the number of people sharing information about patients in facilities, the potential for improper disclosure is greater than ever before.

The rules, until 1978, did not provide sufficient protection for psychiatric records. In a public hospital, for example, no distinction is made between psychiatric-patient records and others. While the improper release of information dealing with a surgical patient's broken leg may cause the patient little harm, to reveal details of the history and diagnosis of a psychiatric patient could not only cause the person serious psychological harm, it could well jeopardize the person's entire treatment program.

Further, while The Public Hospitals Act and The Mental Hospitals Act have provided extensive regulations affecting the release of records, this legislation applies only to certain psychiatric facilities. Many facilities listed under The Mental Health Act had little or no guidance in this area.

So the issue of confidentiality has been moved from the regulations dealing with hospital administration to the primary legislation affecting the care of psychiatric patients.

Permissible exceptions

Under the provisions, the officer in charge and the attending physician at the psychiatric facility in which a clinical record is prepared may examine the record, and the officer in charge *may* disclose or transmit it to, or permit its examination by:

- *any person, with the patient's consent,* where the patient has attained the age of majority and is mentally competent;
- *any person, with the consent of the patient's nearest relative,* where the patient has not attained the age of majority or is not mentally competent;
- *any person employed in a psychiatric facility,* for the assessment or treatment of the patient;

- *the chief executive officer of a health facility* currently involved in the direct health care of the patient, on written request to the officer in charge;
- *any person currently involved in the direct health care of the patient in a health facility,* where delay in obtaining consent would endanger the patient's life, a limb or a vital organ; or
- *any person, for the purpose of research,* academic pursuits, or the compilation of statistical data.

Additions are significant

The new 1978 provisions establish that disclosure may be made *in most situations* only with the consent of patients or their nearest relative.

The exceptions cover hospital staff involved in the patient's treatment. They include the administrator of another facility currently treating the patient. This is particularly important for provincial psychiatric hospitals, since individuals are often transferred to other facilities and suitable provision must be made for appropriate records to accompany them.

In emergencies, too, disclosure is permissible to anyone in a health facility who is currently involved in the care of a former patient. And information may be released for the purpose of research, academic pursuits or the assembly of data.

A prescribed consent form must be used

Where records are released under the authority of a consent, the form of that consent is not left to the discretion of individual psychiatric facilities.

A designated consent form (Form 14) is provided in the regulations of the Act. It requires, in the information to be included, the identity of the facility in possession of the clinical records, and of the person to whom the information is being made available.

Form 14 must also be used when consent to disclosure of information is sought about patients in general hospitals whose primary care is psychiatric.

Patient's identity is protected

The provisions require that where a clinical record is transmitted or copied for use *outside* the psychiatric facility "for the purpose of research, academic pursuits, or the compilation of statistical data," the officer in charge of the facility shall remove from the record *the name of, and any means of identifying, the patient.*

The person who examines the record *shall not disclose the name of the patient or any means of identifying the patient.*

These prohibitions have been established because it is important to ensure protection of the identity of the individual.

Disclosure in court permissible only where essential in the interests of justice

A provision of the Act directs the officer in charge of a psychiatric facility to disclose, transmit or permit the examination of a clinical record pursuant to a subpoena, order, notice or similar requirement, in respect of a matter that is or may be in issue "in a Court of competent jurisdiction" or pursuant to specific access provisions under this or any other Act. For example, this would include the power, under this or other legislation, to inspect or receive information from clinical records of psychiatric facilities.

However, if the attending physician is of the opinion (Form 15) that this disclosure is likely to harm the treatment or recovery of the patient, or harm a third person, the court is granted authority by the amended Mental Health Act to protect the records from disclosure. The court will not order disclosure unless *satisfied that to do so is essential in the interests of justice.*

Further, any person in a psychiatric facility who obtains information in the course of his or her duties may disclose this information in court only with the consent of the patient or the patient's nearest relative, *unless the court orders that such disclosure is essential in the interests of justice.*

The above provisions do not apply to matters under federal jurisdiction (for example, Criminal Code matters) or to mental health professionals in private practice unrelated to a psychiatric facility. The former are outside provincial jurisdiction; the latter, practising outside a psychiatric facility, are not affected by these provisions.

Significance of these additions

The character of effective psychiatric examination and treatment requires the therapist *to have the fullest disclosure from patients* of anything that may bear on their condition.

The public interest in the treatment of mentally disturbed patients requires that *communication during their examination* should be "privileged." A patient's belief in the complete confidentiality of communications made to mental health workers has a significant effect on the frankness of disclosure and on the effectiveness of treatment.

Current psychiatric hospital practice reflects the development of treatment teams that require all members to contribute to the facility record. To be forced to reveal this information could have an injurious effect on the overall treatment, could result in a breakdown in the staff-patient relationship, and could undermine the confidence patients and their families have in the facility.

Patients' competence to manage their estates

The Act specifies that "upon the admission of a patient to a psychiatric facility a physician shall examine the patient to determine *whether or not he is competent to manage his estate.*"

But many individuals who are not formally *in-patients* of a psychiatric facility require the intervention of the public trustee, because of their incompetence to manage their estates.

Prior to 1978, such individuals would have had to be admitted to a psychiatric facility to obtain the assistance of the public trustee, through a Certificate of Incompetence.

Significant advance

This difficulty was overcome in 1978 by extending the application of the certificate to out-patients, who may now be examined by a physician.

The examination of out-patients is discretionary. Consequently, examinations will be conducted on out-patients only in instances where a physician is alerted to a situation that may call for the assistance of the public trustee.

May avoid need to proceed under Mental Incompetency Act

This change also avoids, in some instances, the need to proceed under The Mental Incompetency Act, the only other option for persons, who are *not in-patients* of psychiatric facilities, who have demonstrated a lack of competence to manage their estates.

However, someone such as a relative of the patient can at any time apply to be appointed committee (legally appointed representative) of the estate under the Mental Incompetency Act and, upon such an appointment, the public trustee ceases to be committee and must account for and transfer the estate to the person appointed.

The Act requires the physician to decide if the individual is competent to manage his or her estate. This determination must be entered by the physician in the clinical record, *together with written reasons.*

This gives others working with the patient some indication of the competence of the individual.

Moreover, other physicians coming on the scene some months later should have available the reasons why patients were found competent or incompetent, to help them in making decisions on this issue in the future.

Certificate of Incompetence

The physician who performs the examination, and who is of the opinion that the patient or out-patient is not competent to manage his or her estate, issues a Certificate of Incompetence (Form 21), which the officer in charge transmits to the public trustee.

Appeal to regional review boards

Patients whose control over their estates has been removed by a Certificate of Incompetence have the right to challenge the decision (Form 18) through the regional review boards.

In the past, the patient could apply only once in any 12-month period. The 1978 amendments changed this to once in any six-month period.

Cancellation of Certificate of Incompetence

A physician may examine an incompetent patient at any time to determine whether or not the patient continues to be incompetent. Should the physician determine that the patient is no longer incompetent, a Notice of Cancellation of the Certificate of Incompetence (Form 23) will be issued by the physician, whereupon the public trustee will return to the patient the control of his or her estate.

When the public trustee becomes committee

The public trustee becomes committee of the estate of a patient or out-patient and assumes management of the estate on receiving a Certificate of Incompetence; on notice by the officer in charge or the attending physician of the existence of an emergency; or on receiving a voluntary appointment in writing, signed and sealed by a patient or out-patient; and continues to serve as committee after discharge of the patient or out-patient on receipt of a Notice of Continuance (Form 24).

When the public trustee ceases to be committee

The public trustee ceases to be committee of the estate of a patient or out-patient, and must relinquish management over the estate, on receiving a Notice of Cancellation of the Certificate of Incompetence; on receiving revocation in writing of an appointment, signed and sealed by the patient or out-patient; on receiving Notice of Discharge of the patient or out-patient, unless he has received a Notice of Continuance; or on the expiration of six months following discharge of the patient or out-patient where a Notice of Continuance was received, unless a court order extending the committeeship was obtained.

The six-month period mentioned above is double the period of three months in effect in the past. The change was made because experience has shown that many patients discharged from a psychiatric facility, lacking competence to manage their estates, continue to require the assistance of the public trustee for a considerable time.

1983 Amendments

A 1983 change to both the Powers of Attorney Act and to the Mental Health Act permits someone, while they are competent, to designate someone else (usually a relative or friend) to manage their estate should they become incompetent in this regard in lieu of the Public Trustee.

Examination of a patient before discharge

Where the public trustee is managing the estate, the attending physician must examine the patient or out-patient within 21 days before this persion is discharged from a psychiatric facility, to determine whether this person will be competent to manage his or her estate on discharge. The old provision simply stated that "a patient who is about to be discharged . . . shall be examined . . ."

This three-week provision permits a Notice of Continuance (Form 24) to be issued for patients discharged from settings different from the psychiatric facility, without necessarily requiring their return to that facility for a re-examination as to their competence to manage their estates at time of discharge. (This 1978 change is also consistent with an amendment to The Developmental Services Act.)

Notice of discharge

The officer in charge must transmit to the public trustee notice of the discharge from the psychiatric facility of a patient or out-patient in respect of whom a Certificate of Incompetence is in force.

Supreme Court may extend six-month period

A new provision as of 1978 has been added to demonstrate clearly the ability of the provincial Supreme Court to extend the period of authority of the public trustee over the estate of an incompetent individual *beyond the six-month period following discharge* where the Notice of Continuance automatically terminates.

The patient, or someone on the patient's behalf, may apply to the Supreme Court at any time to terminate its order.

Accounting

The public trustee may be required to render an account of the manner in which he has managed the property of a patient or out-patient, in the same way and with the same responsbility as any trustee, guardian or committee appointed for a similar purpose may be called to account.

Compensation

The public trustee may be allowed compensation "for services rendered" in an amount not greater than a trustee would be allowed for similar services.

In cases of poverty or hardship, however, the public trustee may agree to serve without compensation.

Fine for an offence increased from $500 to $10,000 limit

The old provision of the Act stated that every person who contravened any provision of this Act or the regulations — or was a party to the contravention, either directly or indirectly — was guilty of an offence and, on summary conviction, liable to a fine of "not less than $25 and not more than $500."

The 1978 amendment states that "every person who contravenes any provision of this Act or the regulations is guilty of an offence and on summary conviction is liable to *a fine of not more than $10,000*.

APPENDIX I

Glossary of terms

- *"five days"* — is used in place of the legislative term "120 hours."
- *"Form"* — refers to the Forms used under the Act, which are described in Appendix II.

Definition of terms

Many of the existing definitions were not changed in 1978. For example:

- *"attending physician"* means the physician responsible for the observation, care and treatment of a patient.
- *"mental disorder"* means any disease or disability of the mind.
- *"patient"* means a person under observation, care and treatment in a psychiatric facility.
- *"psychiatric facility"* means a facility for the observation, care and treatment of persons suffering from mental disorder, and designated as such by the regulators.

General hospitals designated as "psychiatric facilities" are psychiatric facilities only in respect of those persons admitted as patients or registered as out-patients of the psychiatric unit or service. (Only those psychiatric facilities designated in Schedule 1 of Regulation 609 have the authority to *detain* persons under the Act.)

- *"physician"* means a legally qualified medical practitioner.
- *"psychiatrist"* means a physician who holds a specialist's certificate in psychiatry issued by the Royal College of Physicians and Surgeons of Canada or equivalent qualification acceptable to the Minister of Health.

New definitions

The 1978 amendments defining terms and concepts not previously covered in the Act include:

- *"restrain"* means keep under control by the minimal use of such force, mechanical means or chemicals as is reasonable, having regard to the physical and mental condition of the patient.
- *"involuntary patient"* means a person detained in a psychiatric facility under a Certificate of Involuntary Admission or a Certificate of Renewal

This definition makes it clear that persons detained for "assessment" are not "involuntary patients."

Thus, persons brought into hospital on the authority of a single physician, usually a general practitioner, and held on the basis of a Form 1, will no longer be labelled "involuntary patients," although they are patients of the facility.

The term "voluntary patient" means just that, and the term "informal patient," in this booklet and in the legislation, means exactly the same thing — a patient in a psychiatric facility on his or her own free will.

- *"mentally competent"* means having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent.

The phrase applies to a patient's ability to consent to the release of his or her records, as well as to an involuntary patient's ability to accept or refuse treatment.

It does *not,* however, include *competence to manage his or her estate.* That is contained in another section of the Act as a separate procedure for estate management, using the public trustee.

The actual test for mental competence is left to the judgement of a physician. The test may differ, depending upon the intended function or purpose for which consent is sought.

- *"nearest relative"* means the spouse, who is of any age and mentally competent; or, in each case, if there are none or if one is not available, the following in this order: any one of the children of the age of majority and mentally competent; or either of the parents who is mentally competent, or the guardian; or any one of the brothers or sisters of the age of majority and mentally competent; or any other of the next of kin of the age of majority and mentally competent.

This 1978 definition for "*nearest relative*" establishes an order of preference among relatives to be consulted where a patient is under the age of majority or is incompetent to consent to the release of information from his or her clinical record, or where an involuntary patient is under the age of majority or is incompetent to consent to treatment.

Mental health workers now have clear direction as to *which relatives* can provide substituted consent, and *in which order of priority* they are to be considered.

- *"out-patient"* means a person registered in a psychiatric facility for observation, or treatment, or both, but who is not admitted as an in-patient.

This new definition is necessary for the amendments dealing with the confidentiality of clinical records and the role of the public trustee.

Form Number	Form Name	Corresponding Section of Act	Who Signs	When	Expiration Date
1	Application By Physician For Psychiatric Assessment	9	Any physician	Within seven days after the examination	Seven days after signed
2	Order For Assessment By Justice Of The Peace	10	Justice of the Peace	No statutory time restriction	Seven days from and including the day it is made.
3	Certificate of Involuntary Admission	14(1)(c)	Attending physician (Different than the physician who completed Form 1)	Before the expiration of five days (120 hours) from time of admission for Section 9 patient; at any time to change the status of an informal patient (Section 13).	Two weeks
4	Certificate of Renewal	14(4)(b)&(5)	Attending Physician	Refer to Section 14(4)(b)	Refer to Section 13(3a)
5	Change To Informal Status	14(7)	Attending Physician	Whenever deemed appropriate	N/A
6	Order For Attendance For Examination	15(1)	Judge	When person appears before him charged with or convicted of an offence	No statutory time restriction
7	Order For Attendance For Treatment	15(3)	Judge	Following report by a physician	No statutory time restriction
8	Order For Admission	16(1)	Judge	When person in custody appears before him charged with or convicted of an offence	No statutory time restriction on time within which order must be executed. Once executed, authorizes dentention for up to two months

Form Number	Form Name	Corresponding Section of Act	Who Signs	When	Expiration Date
9	Order For Return	22(1)(b)	Officer-in-charge of psychiatric facility	When the absence of a person who is subject to detention becomes known to the officer-in-charge (No order necessary for initial 24 hours)	One month after absence became known to officer-in-charge
10	Memorandum of Transfer	23(1)	Officer-in-charge	At any time, under certain conditions.	No statutory time restriction. If involuntary patients transferred, detention subject to limitations on certificates.
11	Transfer To A Public Hospital	24(1)	Officer-in-charge	Same as Form 10	Same as Form 10
12	Warrant For Transfer From Ontario To Another Jurisdiction	25	Minister of Health	No statutory time restriction	No statutory time restriction
13	Order To Admit A Person Coming Into Ontario	26	Minister of Health	No statutory time restriction	No statutory time restriction on time within which order must be executed; once executed, authorizes detention for up to five days (120 hours)
14	Consent To The Disclosure, Transmittal Or Examination Of A Clinical Record	29(3)(d) 29(3)(b)	Patient or Nearest Relative	No statutory time restriction	No statutory time restriction

Form Number	Form Name	Corresponding Section of Act	Who Signs	When	Expiration Date
15	Statement By Attending Physician Under Subsection 6 Of Section 29 Of The Act	29(6)	Attending physician	When disclosure required by Court or under an Act and certain conditions exist.	No statutory time restriction
16	Application To Regional Review Board Under Section 30a(2) Of The Act	30a(2)	Involuntary patient or anyone on his behalf; Minister of Health, Deputy Minister, officer-in-charge	Refer to Section 31(2)	No statutory time restriction
17	Notice To Regional Review Board	31(4)	Officer-in-charge	On completion of every fourth certificate of renewal	N/A
18	Application To Regional Review Board Under Section 43 Of The Act	43(1)	Patient	Any time after certificate of incompetence or notice of continuance is issued. (Once in any six-month period).	No statutory time restriction
19	Application To Regional Review Board Under Section 35 Of The Act	35(4)	Officer-in-charge and attending physician	No statutory time restriction	No statutory time restriction

Form Number	Form Name	Corresponding Section of Act	Who Signs	When	Expiration Date
20	Statement In Support Of Application Under Section 35 Of The Act	35(4)	Attending physician, and a psychiatrist who is a member of the medical staff; and a psychiatrist who is not	No statutory time restriction	No statutory time restriction
21	Certificate Of Incompetence	36(4)	The physician who performs an examination under Section 36(1) or 36(2)	No statutory time restriction	Refer to Sections 40, 42, and 43
22	Financial Statement	39	Responsible Relative or Friend	As soon as possible after the Public Trustee becomes committee of the estate of a patient or out-patient	N/A
23	Notice Of Cancellation Of Certificate Of Incompetence	40	Physician who performs the examination	No statutory time restriction	No statutory time restriction
24	Notice Of Continuance	41(2)	Physician who performs the examination in S. 41(1)	No statutory time restriction	Six months following discharge

Ministry of Health

Ontario

Keith C. Norton, Minister

ISBN 0-7743-8966-4
118661 3/84 30M